HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Suicide prevention: follow-up, HC 1825

Tuesday 22 January 2019

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Rosie Cooper; Diana Johnson; Andrew Selous; Derek Thomas; Martin Vickers; Dr Paul Williams; Dr Philippa Whitford.

Questions 1 – 83

Witnesses

I: Ruth Sutherland, Chief Executive, Samaritans; Dr Peter Aitken, Member of the Liaison Faculty at the Royal College of Psychiatrists, and executive lead for suicide prevention in the trust, Devon Partnership Trust; Hamish Elvidge, Chair, Matthew Elvidge Foundation; and Councillor Richard Kemp, Deputy Chair of Community Wellbeing Board, Local Government Association.

II: Professor Louis Appleby, Chair of the National Suicide Prevention Strategy Advisory Group.

III: Jackie Doyle-Price, Parliamentary Under-Secretary of State for Mental Health, Inequalities and Suicide Prevention, Department for Health and Social Care; Professor John Newton, Director of Health Improvement, Public Health England; and Professor Tim Kendall, Mental Health National Clinical Director for NHS England.

Written evidence from witnesses:

– Royal College of Psychiatrists

Examination of witnesses

Witnesses: Ruth Sutherland, Dr Aitken, Hamish Elvidge and Councillor Kemp.

Q1 **Chair:** Good afternoon, and welcome to the Health and Social Care Select Committee. This is a really important session following up on suicide prevention and the recent update from the Government. Could all members of our panel introduce themselves to those following from outside the room and say who they represent?

Dr Aitken: I am Dr Peter Aitken. I am a consultant psychiatrist in Exeter, and I am representing the Royal College of Psychiatrists.

Ruth Sutherland: I am Ruth Sutherland. I am the chief executive of Samaritans.

Hamish Elvidge: I am Hamish Elvidge, chair of the Matthew Elvidge Trust, which was formed just after our son took his own life; chair of the Support After Suicide Partnership; and an adviser to Universities UK on their mental health advisory board.

Councillor Kemp: I am Councillor Richard Kemp. For my sins, I am the longest serving councillor in Liverpool, but I am here representing the Local Government Association as deputy chair of the community wellbeing board.

Q2 **Chair:** Thank you. We have a huge amount to cover this afternoon, so, if you agree with a colleague on the panel, please do not feel that you need to repeat; just let us know that you agree. We are interested to hear any further points that you want to add.

We would like to start by hearing from each of you where you feel we have made the most progress but also, for you, the key points you would like to make about where there is further to go.

Ruth Sutherland: Thank you for the opportunity to return to discuss progress. You have kept this so close and we really appreciate your level of concern with everything.

Significant progress has been made. It is fantastic that the NHS England money is hitting the ground, that we have a national delivery group and that practically every area has a suicide prevention plan. It really is great. Five years ago, I never would have thought we would have got where we are with this, but activity and impact have not been proportionate to the priority that I think the Health Select Committee or Government intended or that is needed. Every delay, every prevarication, every loss of strategic focus is a missed opportunity to save lives—4,451 lives lost in 2017—and we know the devastation caused by each of those lives lost.

We know that suicide is preventable and that we can and must do better. My observation is that it is too slow and it has not yet been balanced,

targeted or fully supported in places that might make the most difference.

The suicide prevention strategy is a public health strategy because population, multi-sectoral and societal action is required to prevent suicide. Suicide is complex and we know there is no magic bullet, yet public health remains the poor relation in all of this. It is fundamentally right that no one should die in care or custody. As a taxpayer, as a citizen, the least we should expect is that. Most of the action has been in that area and it is right that it is, but we must balance that with better targeting of the two thirds of people who die who are not in contact with mental health services. I hope I get the opportunity to talk about local plans, but that is where I think we are.

Chair: Very much so. Thank you.

Hamish Elvidge: I reiterate my thanks to the Committee for raising the profile of suicide prevention and bereavement support.

I similarly think there have been a lot of encouraging signs around the delivery group and the quality of self-assessment. One particular thing that is of great importance to me is the fact that NHS England is so much supporting suicide prevention and bereavement support, which I can talk about a little later, and that we have a Minister for suicide prevention, which is such an important signal to everybody involved. There is lots of encouragement.

The area about which I have concern is the visibility of the quality of the local authority plans. We still do not have that, and it is two years since we made the recommendations. Also, I have a concern about some of the scope, vision and ambition in the content of the work plan.

If I take two that are of interest to me—information sharing and the consensus statement and the training of primary care staff—what confidence do we have that the work plan sets out a vision and ambition, and has the resource and an implementation plan such that we are confident that change in culture and practice will occur? I do not think we have that, and you could ask that question about all the items in the work plan and test it out in that way.

Chair: We are going to come back specifically to look at the consensus statement in some detail.

Councillor Kemp: Since the four of us appeared before you two years ago, we have been trying to do what we said we would do on that occasion. Then we had 145 out of 151 authorities with a suicide prevention strategy. Now we have 149 out of 151, and one of the last two will be completing the process in March.

We very much pick up what Hamish said. There is still differential performance in the strategies, as there is in almost everything; some hospitals do better than others and some GP practices do better than

others. We have been trying to drive up the performance of local government because we have dealt in some ways with the quantity level. Since then, we have produced a document—we had a conference about it—which is trying to give good practice for local authorities. We can let Committee members have it. To make sure that things are being properly aired in public, we have worked with the Centre for Public Scrutiny to produce some guidelines for health select committees of councils, looking at what they should do—not just upper-tier councils but, of course, district councils, which often have a view on health issues in their area.

As we look forward, we welcome the letter we received from Jackie Doyle-Price that supported the work we are doing in sector-led improvement. In today's plan, which was announced this morning—or certainly I got it this morning—we see that there is support for that, and we would like to turn the support into a practical programme.

We are ready to do it as soon as someone says when the money will arrive, but it would be wrong of me not to mention today the fact that we are getting £25 million—or the NHS is—for suicide prevention work over three years, when in the next financial year alone we are losing £80 million from our global public health budget. We have lost £531 million, which is about a third of our public health budget in real terms, since 2015.

Chair: We are going to talk specifically about funding in more detail later.

Councillor Kemp: Fine. I can give you some more information.

Q3 **Chair:** That is super. Finally, Peter, can you respond to what you have heard but, very importantly, what you hear from your perspective in the royal college?

Dr Aitken: I agree completely with what my colleagues have said. We share the view that with so many people taking their own lives, away from mental health services and away from any kind of in-patient or custodial space, it is imperative that we think a bit about action that can be taken in the community space as a matter of priority.

Having said that, the NHS has benefited hugely from the attention and focus that this Committee has given to the work. Probably the most important thing is that we are now getting to a place, thanks to the national confidential inquiry, to understand 10 clear areas for action in specialist mental health providers that would make a difference.

The Committee would welcome hearing the list: secure safer wards; giving priority to making sure that people are followed up properly on discharge; work to eradicate out-of-area admissions, and we note some concerns that maybe that is not progressing quite on the track we might have hoped; a full and effective range of 24-hour crisis resolution and home treatment services; the benefit of having a core 24 liaison psychiatry service in most English hospitals with an A&E department; not

overlooking the importance of family involvement; delivering perfect depression care; and the notion of personalised risk reduction rather than risk assessments to perhaps less purpose. Those are subtle changes, but they are nevertheless very important in making realistic change.

Then there is making sure that our outreach teams are in place. There is something very important about staff turnover. It is quite clear that services where there is high staff turnover and a lot of agency staff being used seem to be less safe than services where there is continuity and strong leadership. Last but by no means least, and something I would return to the group, is, what on earth are we doing to improve the position in relation to drug and alcohol services?

Chair: Thank you very much. We are going to talk about implementation, and I know, Hamish, you spoke about that when you came to the Committee last.

Q4 **Andrew Selous:** What is the reason why the Local Government Association has refused to allow local authority suicide prevention plans to be audited and quality assured? That seems a very odd line to take. What is the reason for that?

Hamish Elvidge: I am happy to start off with a perspective and I am sure others will say what they think. I do not think they have refused. The Association of Directors of Public Health and the Local Government Association have been working with the Department of Health and Public Health England on the most appropriate way to do quality self-assessment. It has been agreed that it would be done on a self-improvement basis. The quality self-assessment has been done, it is being analysed by an expert panel in February and April, and there will be a report after that. That will identify good practice and some areas to improve.

The concern I have about it—clearly, you have a concern too—is that there appears to be a lack of transparency around individual areas. For example, we will not know which areas do not have effective bereavement support, which is an example of mine. We will know the percentage of areas that do and the percentages that do not, but we will not have total transparency by local area, which I think is a concern.

Self-improvement is a good model to drive change and improvement. At this stage, we should see how that goes, see what the report says and make sure that we apply the learning from the report right across every local area to ensure that all areas are improving all the time.

Q5 **Andrew Selous:** What is your assessment of where we are with overall implementation nationally and with the vision for this important area?

Hamish Elvidge: We have made an important step, which is that the delivery group was formed in the middle of 2018. The concern I have is that it has no resource, it has no authority and there is no real programme management capability within the delivery group. It is

chaired by Public Health England, and a number of Government Departments are represented. It has a work plan, which was published today alongside the Government's fourth annual review, but I am worried—maybe I am worrying too early; it is early days—that it is not a fully empowered group, which I sense is what the Committee was seeking. That is due to lack of resource and authority.

I am also concerned that it cannot provide the leadership without the authority. To take the consensus statement or primary care education, we do not have a clear work plan to implement that effectively across all areas where it is needed. I wonder whether the delivery group as it is currently set up will have that capability, but maybe I should not make that judgment so early.

Q6 **Andrew Selous:** That is very helpful, thank you. Ruth, do you want to come in?

Ruth Sutherland: A lot of key Ministries are missing from the group—DWP, housing, communities and local government, business and energy, environment, food and rural health. When we take the more public health approach, some of the people are listed in the progress report as delivering activity, such as the Farming Community Network, but their Government Department is not represented in the work plan.

For me, it is the synergy between the national and the local; we cannot yet see the golden thread between things—we cannot see where action will be—so I agree with Hamish that there is lack of coherence in the leadership. Cross-cutting targets could jointly be owned across Departments.

The 10% suicide reduction target is not granular enough. The 2007 rate of suicide is less than we will achieve in the 10%. Is the extent of our ambition that we want to go back to 2007? Of course, we were at low rates in 2007 because we were pre-recession. Understanding where all the drivers of suicide come from is much wider than health and education.

Councillor Kemp: I want first to suggest that Andrew is wrong in his suggestion that the Local Government Association has refused to do anything. We are suggesting that there is a better way. There is an old saying: one volunteer is better than 10 pressed men. We have local authorities transparently developing strategies and doing something about them.

I stress transparency. The strategy will have had to be approved by the cabinet and/or the health and wellbeing board, both of which meet in public, and their documentation is public. The plans will have been scrutinised in most cases by the select committee, which again meets in public. There are not only councillors on that but representatives of the voluntary sector—Samaritans, in some cases—so we are trying to improve things, but we accept that some authorities have a way to go.

The answer is not regulation; it is self-improvement. I have been an inspector of councils and the idea that national regulation does things is, I think, naive.

Q7 **Andrew Selous:** I am going to read you one sentence from our brief—perhaps we can correspond about this afterwards—just to get it on the record. I am quoting from the brief given to Committee members by our Committee specialist: "Many months have been lost with the LGA's refusal to allow Local Authority Suicide Prevention Plans to be audited and quality assured independently by central Government and potentially graded accordingly." That was the statement I was referencing, but I fully accept that the LGA may have a different view, so perhaps we could follow that up with correspondence.

Councillor Kemp: To be clear, the LGA is a member body. We cannot instruct our councils to do anything, never mind refuse something, but, yes, let us follow that up so that we understand the detail.

Andrew Selous: Thank you.

Q8 **Dr Williams:** I want to explore the association between debt and benefits and suicide. A person who lived in my constituency took her own life a couple of years ago after being sanctioned by the DWP. I was surprised to learn that in the implementation group there does not seem to be a DWP representative. What is that association, how widespread is it and how important should it be that the DWP are involved?

Ruth Sutherland: Suicide is very complex; it can never be any one thing, but it is obviously in the basket. Certainly, from a Samaritans perspective, of the 5.5 million contacts we have per year, there would be a high proportion of people who are very anxious and worried about their benefits situation; they get a letter or something that is a trigger, but there are usually lots of other things going on.

One of the things the progress report talks about is that now, if a death is thought to be associated with something do with benefits, the DWP is required to do a review of the case. We see that as a positive step forward. You could equally take evidence from Citizens Advice, who would also tell you about the volume of people who are extremely anxious about benefits and the impact on their wellbeing.

Dr Whitford: In relation to what Paul was talking about, in the Scottish data, the most deprived have three times the rate of taking their own life than the least deprived, but among the other group, a quarter of women who are lost to suicide have had a baby in recent times—post-natal depression.

We often talk about health in all policies and we really need that here. It is fine that groups are doing a review, but in fact if they are not part of developing the prevention plan, that every woman should have a contact— "How are you doing?"—quite quickly after giving birth, we are missing the opportunities to prevent it, as opposed to looking at it later.

Chair: We are going to come on to more about prevention shortly. I am keen that we should have a chance to talk about funding.

Q9 **Martin Vickers:** Funding, of course, is going to be particularly contentious. I understand that, because I recognise that, whichever organisation you represent, more resources would obviously allow you to do more. Richard has already mentioned in his opening remarks the reductions in local authority funding, which we all recognise, but you also talked about best-performing authorities. It goes without saying, but are the best-performing authorities using their resources better, and what are you doing to spread that good practice throughout local authorities?

Councillor Kemp: That is the whole purpose of the programme the Government have agreed to today, and I am waiting for the cheque for that. We want to make sure that good practice is taken through every part of local government. Martin is right that money is not the only thing: it is attitude, it is competence, it is ideas, and often it is the quality of the partnership.

On a wider level, there are areas where the NHS and councils work together very closely, so it is likely that they are working together very closely on this issue. We know there are other areas—I am not apportioning blame—where that partnership does not exist, but you cannot do things without money. Money is not the solution, but there are probably no solutions without money.

We have really been hit on our public health budgets. I noticed that one member said that he wants, as do the Government, to move from curing illness to preventing it. That is the local government viewpoint, but when we face the level of cuts not only to our public health budget but to all services—housing, environmental health, environmental maintenance, employment—people are falling through the net at the basic level before they start to get suicidal, because the parks and the libraries are not running properly and things like that. That is why policies have to be across the whole of a council, and councils have been taking some stick, as everyone here knows.

Q10 **Martin Vickers:** Could I ask the other panel members if they would look at it from their perspective, in particular how the NHS is using its resources?

Ruth Sutherland: We said at the time that the money was too little and in the wrong place. We would still argue that the money would be better going directly to local authorities. We are still disappointed that there is not ring-fenced money for suicide prevention with the people who have the lead responsibility, the directors of public health in local areas.

Of the £25 million, we are pleased that it is going to the STPs, which is a good compromise in a way, but it is a finite, small amount of money, and when you have a small amount of money, you need to make sure that it is making the most difference. There is a scarcity of evidence about what

works, but I still think that we are spending on things when we do not know whether they are going to work or not, so there is the evidence thing.

There is also duplication. There are high-frequency locations all over the country. The only body that has a national view of that is in the rail estate—the rail industry. If high-frequency locations are not in the rail industry, nobody can tell you about the national picture of what is happening in each of those. Public Health England provides good guidance on high-frequency locations, so there is an evidence base to use, but nobody knows what works where. If you are a local authority and you have one of those in your area, you have nowhere to go to find out what works, so you could be spending money on things that you think might be a good idea. We are wasting money in that way.

Most of the original money—the first tranche of money—is being spent on training and campaigning. Most local authorities are having to work out which is the best solution for them. Public Health England and the Department of Health are working on a national mental health literacy campaign that is being piloted at the moment in the West Midlands, yet a local authority has to invent its own.

Are we not confusing the public? Are we not wasting money on individual market research of audiences in each location rather than providing a kit that would enable a local authority to say, "This is the campaign kit, and this is the training I am going to use, because here is the evidence base"? Why are we not making it easier for local authorities to spend their money wisely?

Q11 **Martin Vickers:** Dr Aitken, did you want to come in?

Dr Aitken: The focus has been on the £25 million, but I would like to share the success of the five year forward view for mental health investments, which has begun to reveal some of the historical gaps where mental health care was almost absent—for example, in general health pathways—and is extending psychological therapies to people who present with physical symptoms.

The expansion of IAPT and the implementation of core 24 liaison services has gone a long way to improving access for people who might not otherwise have had access. We touched on perinatal care, and there has been an investment in perinatal psychiatry that is bringing to life mother and baby units and the infrastructure that comes with them in the community, which is a help.

Those are separate funding streams from the £25 million, but they have an impact, because while, thankfully, taking one's own life is a rare event, it is a slightly less rare event in the context of mental health services than it is in the wider community. We look at the 10-year plan, the long-term plan, with some enthusiasm, because the consequence of the targeted investments over the last five years has been to some

extent at the expense of what we might call core mental health services—the community mental health teams, crisis and home treatment teams who have historically looked after some of the most vulnerable and needful people in society. The 10-year plan ahead will seek to redress that.

The missing ingredient has been, until now, knowing what specifically to train our staff to do. I very much welcome the three competency frameworks that were launched by Health Education England in October because, for the first time, it is beginning to be clear in the evidence what works when you are talking to a vulnerable person you know; what might be different about talking to a stranger; what might be different if you are a qualified health or social care professional and what might be different if you are a specialist mental health professional.

The notion that we are beginning to think more carefully about the skills and techniques of engaging with vulnerable people, having a meaningful interaction, being warm, empathetic and engaging and then being in a position to take people to the right kind of help, is beginning to bring some skill and depth to this world.

In the corridor before we came in, we were discussing how, no matter how good you are at co-creating a safety plan, if you have nothing in your community to deliver against that plan, you are struggling. The basic necessities are a place to live, relationships in and around you, food and drink, nourishment, being safe at night and being safe over a weekend. Those are the kinds of things that tax me.

I am still a frontline psychiatrist and I am still in police stations and community settings at night on a regular basis. It is extremely difficult in a remote rural area of England to put together a decent safety plan for somebody after about 11 o'clock at night and before 7 o'clock in the morning. We have a long way to go, but there are some encouraging signs in the long-term plan.

Q12 **Martin Vickers:** Mr Elvidge, before you come in, could I broaden the question about funding? Perhaps with your experience, you might be able to talk about the interaction you have had with other agencies, such as those who manage our major infrastructure. Where do they fit into the funding streams and how can they help?

Hamish Elvidge: I cannot answer all those questions. I was going to make all the points that Ruth made. Taking high-risk locations as an example, no doubt we have about 140 high-risk location strategies, but we do not know how effective they all are and whether, if you add them all up, we are prioritising high-risk locations across the country to minimise the risk of people taking their own life. That, to me, is where the vital role of the delivery group would come into play.

All the information should be available to a programme management resource delivery group to enable the right decisions to be made and

good practice to be spread. We are missing a real opportunity in not resourcing that delivery group to be more effective.

Q13 **Martin Vickers:** Do other panel members want to come in on the other agencies issue?

Dr Aitken: That is a point very well made. When one sits down with any group to think a bit about how one would approach the problem, eventually everybody comes to the wise idea that prevention would be better than cure, but the reality for us at the moment is that we have quite a lot of information on what might work around big infrastructure.

For example, being safe around the railway would have saved two lives in my county this weekend. Being safe around the coast would save a lot of lives. The RNLI and the national drowning prevention strategy take that very seriously, and it is not impossible that within the next two or three years 256 lifeboat stations will all know where there are bits of coast that are particularly at risk in and around their area.

I know some work is beginning with Highways England to look at difficult points on the bridge infrastructure. We need to think about targeted, focused interventions around big infrastructure like that and then, to the point made, we would know where other areas of vulnerability might be. I know where they are in my county. I am not going to say them in a public forum because I do not want people to know where they are; nevertheless it is known and things could be done.

What we are missing is the strategic leadership, the vision and the commitment to do it, and to know that it is done and then to be able to share the learning. I absolutely accept the point that we are a series of islands of excellence with some gaps, and it is very difficult to share learning across them for a whole host of reasons. I welcome the approach in the cross-Government document to do something about the information-sharing problem.

Chair: Thank you. We are going to talk a bit more about prevention more widely.

Q14 **Dr Williams:** A member of my family took his own life around five years ago, and he was not at the time in contact with any specialist mental health services. We know that two thirds of people who take their own life are not in contact with specialist mental health services. What progress has been made at community level in terms of prevention for people who are not in contact with services, and what are the next important steps that need to be taken?

Councillor Kemp: One thing I am very pleased about in Liverpool, which is nothing to do with the council, is the fact that Radio City—one of our two radio stations, a commercial one—has an hour every Monday in which they talk about mental health issues. That is sometimes the best way to do it, not someone from officialdom, not a council official, but the radio station. They have talked about suicide prevention strategies, what

to do, what to recognise and what to worry about if your son has not made contact—that sort of thing, very practical work.

We have been concentrating, as local government, on doing that sort of thing, but finding partners such as Radio City and organisations like that, which can take the message out more effectively than us, seems to me to be the major way forward rather than the mayor putting an advert in the paper or an article in the *Echo*. More granular involvement from the bottom up is the way we must spread the message.

Q15 **Dr Williams:** Thank you. Peter Aitken, what progress has been made and what are the next priorities?

Dr Aitken: In the area of the world I know best, which to some extent is the coast, particularly the south-west, what I see working well is when the statutory infrastructure sets itself up in a way to help the thousand flowers that are blooming find success.

The best example I can think of locally to me is the Lions Barber Collective and Tom Chapman's work, simply identifying that men sitting in a barber's chair are liable to have a conversation with the person cutting their hair and, based on personal experience of suicide in their friendship group, thinking it would be a good idea if the barber knew what to listen for and what to do, and then coming to a strategy agency like ourselves and saying, "We have come up with this good idea. Could you have a look at what we are doing and help us improve it or tell us that it is okay?" Statutory mental health services can use their expertise more creatively to help developing third sector initiatives find a way to the most effective interventions for the particular people who want to come to speak to them.

There are a number of examples of that beyond hair. I find them in some of the Men's Sheds environments in and around Devon that are springing up, where again the right expertise is lent to a shared space, helping ordinary people have ordinary conversations with people in difficulty. It is all about improving access, because we know in my county that we have to enable 100 people in 1 million to have the right momentary conversation at the point it most matters to them. That is an extremely difficult thing to cope with.

Dr Williams: I understand.

Hamish Elvidge: I take a slightly different angle. A lot of people do not seek help because of the stigma associated with the experience they are having. Stigma is built of lack of understanding, and lack of understanding is normally built of lack of education. We ought to take this all the way back to our education system.

We need to get ourselves in a position where all young people have the opportunity to understand the importance of mental health and how to keep well, to know the signs of not being well and how to get better themselves if they can with their skills, and to be confident to seek help

and know that the help will be there. We should implement an effective long-term strategy around children and young people's health quicker than we are attempting to at the moment, because at the moment the Green Paper will benefit 25% of our children by 2023.

Q16 **Dr Williams:** That is the service that will benefit those young people, but we have done focus group work with young people and found their level of mental health awareness remarkable. Is it your experience that we still have a long way to go in that direction?

Hamish Elvidge: We still have a long way to go. Health education will only become mandatory in September 2020. Health education includes mental health, and we need a whole generation of young people to benefit from that to get to a point that enables people to seek help more frequently and be fine about that: "It is okay to seek help, because I understand what is happening to me." We have a long way to go yet.

Ruth Sutherland: It is about systematically moving through all the industries. Network Rail provides a really good example, and made a very good commitment, but in the two years since, the construction industry has been kind of waiting. There is Mates in Mind, but it has not had much traction; it does not have as much resource. We have not worked as much as we could on the at-risk occupational groups. There is reference in the reports to the Pearson commission, which we have been involved in, on the health and wellbeing of NHS staff.

Q17 **Dr Williams:** Progress has been made in the medical profession.

Ruth Sutherland: Yes. I think we could push on more, but I endorse the thing about the general public—the campaign that is coming on mental health literacy, and equipping everyone in the country to be able to have that conversation, because that is what will make the most difference. It is what Samaritans is based on.

Dr Aitken: It occurred to me that we might do more with large employers in our areas. I was particularly struck by that when a couple of large employers in my local area were in some sort of business difficulty. When we thought about it, we realised that there would be a large number of men aged 40 to 43 working in the supply chains to those industries, and they could all be in jeopardy if, for any reason, the businesses got into significant difficulty.

It was not clear in the local authority plans, or in our own plans, that we really had the same attention to engaging HR directors in big employers in the suicide prevention space in the way we might if it was an infection-control problem such as pandemic flu. Our major incident planning, our gold and silver emergency commands, are all set up for bad things happening in terms of physical health, or for explosions or infection, but the idea that there might be a serious risk of a cluster of people taking their own life had not occurred, so we are doing something about that.

That took us into another conversation with some of the other major employers in the city who talked about how insurance companies were starting to think about different levels of indemnity for employers who showed good practice around the mental health of their workforce.

Again, this was news to me since I last went out and met civic leaders, and maybe there is something to be done with other major employers in the city around thinking about how they could skill up and resource around the mental health and wellbeing of their workforce, and take responsibility in that way. In turn, we could bring them some training on how to recognise people who are vulnerable or in vulnerable circumstances. I put that into the mix because it has not been in the conversation and it was not in our evidence submission.

Hamish Elvidge: It would be transformational in this space if health was a strategic priority in every organisation. If you take the business world, at the moment individuals are assessed for their performance based on achieving targets and leadership skills and behaviours. We need to move into a world where health is one of the core things they are assessed on.

Health is the foundation because it affects everything you do. Every conversation you have with an employee would start with their health—emotional, mental and physical. That would make a huge change. If you take what Universities UK are doing in their organisation, they have launched suicide-safer universities as part of step change; they are developing an early-alert system to identify students at risk, and working closely with the NHS to create better pathways for care. That is a whole-organisation approach to wellbeing and mental health. If every school, college, university, workplace and jobcentre had that at the heart of what they do as a strategic priority, it would make a huge difference to suicide prevention in this country.

Q18 **Dr Whitford:** That is a wonderful idea. We talk about, as I said earlier, health in all policies, but health and wellbeing is probably the single most important thing to every human being. Do we not need to see that within national Government and in local government in all the decisions we make about all the things that you listed—homes, food, security, and so on?

Hamish Elvidge: One thing Ruth and I talked about before we came in was the idea that if you took every single Government Department and said that health, mental health and suicide prevention was a strategic priority, such that every decision made within that Government Department, both for employees and for the people they serve, makes an assessment against a set of principles around health, wellbeing and suicide prevention, which should be an integral part of health, that would be transformational too.

Councillor Kemp: Perhaps we should all look at the experience of Wales where, frankly, the Welsh Government have made a much greater effort to include health and wellbeing in all their strategies than perhaps any of

the other three Governments, so it can be done, because that is the ultimate test of all our policies. I always quote Liverpool's Professor Kenneth Dodd, who talked about happiness. If everyone is happy, they are not lonely and they are not committing suicide. Our job is to be proponents of happiness in its simplest form. I won't sing it for you, in case you were worried, Chair.

Chair: Thank you. We are going to talk specifically about education, young people and the impact of social media.

Q19 **Derek Thomas:** Thank you for mentioning earlier the need to do more among young people. Obviously, schools and colleges have a front role in promoting and protecting children and young people. More, we know, is being done to create a strong partnership between education and mental health. What further interventions need to be made? Paul is right. The Youth Parliament, for example, is a fantastic organisation, and their priority last year was mental health and how they can support the people they represent. When I go into schools and colleges, they are so focused on the issue and dedicated to it. Where are we missing a trick and what more needs to be done to support young people?

Ruth Sutherland: I would like to talk a little bit about the online environment. It is much wider than social media. A child will spend five hours on a screen, it is thought, from a phone, to the TV, to a computer. It is their life. It is part of their life, and it is not something we are going to control or stop. The approach is to try to make sure that, wherever you are online, you get help, information, education and support first, and that we try to control access to harmful content.

We are in danger of trying to tell the industry and the providers what to do when the thing that would make the most difference would be if we could get more into partnership. One of the things they are very good at is innovation. What innovation could we work with them on to help make sure that people get access to help and support before they get anything else? They have huge data. What can we learn?

From the Bristol University research we put in, we know that people respond to content on suicide differently at different stages of their suicidality. We know so little about people's behaviour online, across all the chat groups and everything like that; it is a massive area of data. If we could be more in partnership, we could understand more about what is going on.

On the media work, we have set up a protocol with Public Health England. We were very disappointed that the IPSO regulation did not strengthen the code. It was a recommendation. We all submitted to the consultation and we all followed it up, but they will not strengthen the code. The code is just not good enough. We will not be able to get anywhere because the code is too weak. That is another area where we need more, because young people are more suggestible than any other age group over how suicide is reported. It would make the most

difference to that age group, particularly the link with celebrity suicide and all that kind of thing.

Hamish Elvidge: I go back to education, because there is a risk that we start trying to take action once the horse has bolted. If we were educating our young people age appropriately from 0, literally, about the online environment, social media and the impact it has on your health—mental, physical and emotional—and it was a continuous and growing understanding, young people would be much more likely to be able to manage themselves what they are experiencing rather than having to be supported further down the line when they are in real difficulty. Education is a mandatory part of prevention.

Councillor Kemp: As well as education per se, there is the role of the education service. We have some real problems with the relationship between education—schools—and CAMHS. We know that 75% of young people who have a mental disorder either do not have it at a level sufficient to be recognised by the NHS at all or they have to wait more than a year for treatment. A year is a long time in a child's life, in anyone's life, but if there is not a relationship with schools, so that teachers, who are hard pressed already to do their job in a highly competitive environment, can recognise things, what do they do and where do they send people if there is no resource available to them? There is a real problem in how we deal with young people and with what happens when we recognise problems.

Q20 **Derek Thomas:** You have just suggested something I had not really thought about—social prescribing. I do not know, Dr Aitken, whether you want to have a look at whether that would work. I see it quite a lot in my constituency among older people and it is taking off in a positive way. Given that there is pressure on CAMHS and there are not always resources in the traditional sense, do you think that for schools, colleges and others involved in supporting, nurturing and mentoring children social prescribing might have a positive impact or could be used and applied?

Dr Aitken: It looks likely, doesn't it? I have more experience of social prescribing at the other end of the age range, but it is quite clear when local GP surgeries run walking groups, for example, that often the talk on the walk is the bit that matters as much as the walk on the walk. I am quite convinced.

There are some great examples from Scotland of children walking miles to school, which were then modelled in Devon, and children wondered why they were getting off the bus at the wrong end of the village and came home and told us their teachers were daft. That worked very well because, again, it was not just the walk—it was the talk and the walk and the opportunity for children to have more informal conversations with teachers outside the structure of the classroom setting.

I am very sensitive to this. My family is full of teachers and doctors, and I feel for teachers and GPs because very often it is, "Let's just give the GP the job," or "Let's just give the teacher the job." As you know, each job has time and training associated with it, and there are competing priorities. Nevertheless, the notion of social prescribing is healthy. We have had examples of blue gym and green gym. There have been lots of very elegant systems set up. The hardest piece is to motivate the most needful to take advantage of the offer. That is the tricky bit—getting people's behaviours to change so that they will do things. I worry that some of those adventures engage with the people who probably are not the people who need to break out of isolation and loneliness.

Q21 **Derek Thomas:** The worried well.

Dr Aitken: That is the difficulty. One other thing for us to think about, however, is some of the stigmatising attitudes and beliefs that we as older people hold regarding youth. I noticed that very much in the RNLI service, when we were starting to think about vulnerable points on the coast and what we might do.

There was a genuine conversation about whether we should involve the lifeguards—lifeguards are between the ages of 16 and 24—and whether it would be reasonable to worry them with an agenda like that. We very quickly decided that the lifeguards might wish to be in on the conversations, and they were considerably more skilled and knowledgeable in the mental health conversation. They knew far more about self-harm; they had seen it up close in their classmates. I think they wondered where the adults were in terms of the lead we were giving.

The maturation of all those conversations in different settings needs a little bit of expert help. To come back to my point, I wonder whether, as we reconfigure and redesign mental health services, we can offer more expertise to help others hold the conversations. I think then the social prescribing thing comes to life.

Q22 **Derek Thomas:** It seems to me that suicide rates among young women—15 to 19—are on the increase. Is there an understanding of why that is and an appropriate response? Ruth, do you want to take that?

Ruth Sutherland: Yes. I am glad you raised it. It was one of the things I felt I had missed out. We do not know enough. We do not know what is going on at this point.

Probably another point is that we are too behind. Things happen and then we have to catch up. We do not know enough about what is going on. We know more about the link between self-harm and suicide than we did before, so we know it is a pathway. That is why we are even more worried about the volume of self-harming in that very young age group. Again, it is something where we should be commissioning more understanding about what is happening in that group.

I agree with Peter about young people being a key resource. They are much more emotionally literate than older generations. Because we have been saying it is good to talk, they are talking. But are we skilled enough at listening? Are we skilled enough at understanding what their solutions are? We have been doing some work with the Prince's Trust, which is not traditionally a mental health organisation; they concentrate on work and training, but they see that 60% of their intake are now people who are self-assessing that they have mental health issues. They are an incredible, vibrant resource for solutions, so we should create more opportunities to be led by what young people want us to do.

Q23 **Derek Thomas:** Can I take you briefly back to the media? We concern ourselves often with the printed press and what we see on the TV when it comes to reporting what is going on, but young people will not be getting information in that way: it will be social media; it will be online. You have touched on this briefly. What can be done to bring the whole of that sector together for them to understand potentially how the internet and social media can cause harm, but also how they can be a force for good? Is there any work you are aware of that is doing that? Is it led by the sector? Are you aware of work that is happening now to try to do that better?

Ruth Sutherland: Yes. We have developed partnerships and arrangements with Facebook and Twitter. We have developed a suicide prevention tool with Facebook and we train their online moderators. With Google, you used to be able to auto-fill "Ways to kill yourself." We have prevented that, asked them to stop doing that. Now if you put in "Ways to kill yourself," a pop-up will send you to help: "Do you need help?"

There is peer-to-peer self-reporting. I agree with Hamish about skills for people to navigate the online world. I would include gaming, which is something we have not paid enough attention to. There are age limits on games, but most young people go for the older age range, something that is not suitable, and adverts are driven to them while they are gaming that are not suitable for their age. There is no regulation or scrutiny of that. Gaming is something to which we should definitely pay more attention.

It is the same thing I said before: trying to make sure with the industry that you are pushing help first. There is a whole debate with the online providers that if you are a publisher of content you have certain responsibilities, and if you are a facilitator of content, like Wikipedia, you seem to have no responsibilities. We need a duty of care. We need the industry to understand that they have a duty of care to the people who use their services. We could push more—I think the Carnegie Trust are doing some work—on what a duty of care might look like for online providers.

Chair: We have a huge amount to get through this afternoon, and I am conscious that we are running over time. I want to come on to bereavement support.

Q24 **Diana Johnson:** Hamish, you mentioned bereavement services when we were talking about local authority plans not being audited to know whether there are bereavement services or not. With the NHS long-term plan setting out that there is a commitment to make bereavement services and support available in all areas of the country, what would that look like? How would it be delivered? That is a question for anybody on the panel.

Hamish Elvidge: The whole landscape has changed since 7 January. Last time, I said we should not rest until all parts of the country had a local support service that is proactive within 72 hours of a death occurring and there for the long term. On 7 January, the long-term plan was published, and there are basically four parts to it on which the Support After Suicide Partnership is working with NHS England.

First, there is funding associated with the £25 million fund. We have been given support to implement between five and 10 services in 2019-20. There are currently about eight services available across the country, so we will nearly double that capacity. NHS England has made a commitment, as you illustrate, that suicide bereavement support for families will be available in all areas of the country, and that is from the long-term fund.

It has also said that post-crisis support for families would be available through the 111 service, which would be very much a start of the journey of referral to local support services. The Support After Suicide Partnership has been given backing to develop a central hub of information and resources that will, essentially, make it much easier for any local area to implement a service.

It is still quite early days in unravelling the long-term plan, and we are working on that, but, as I understand it, a sum of money will be made available to set up services in every area of the country, and they will be commissioned by the lead CCG in an STP. We are working on a list of priority areas to do that. Over time, over the next two years, we are likely to see an increasing number of services available locally, based on the Public Health England guidelines and based on models that already exist and are effective, whether it is in Cornwall, Devon, Merseyside, Leeds or Somerset.

One of the things that concerns me about this is realtime surveillance. For bereavement support to work effectively, it must be built on realtime surveillance, which requires the involvement of the coroner particularly and of the police. They need to be willing, at the point of death, before the inquest, to say, "This is likely to have been a suicide," and support will be available to the family. Support available in six months' time has far less benefit than when it is available now. Families can refuse it, but it should be made available.

I do not know what the protocol is, Chair, but since we have come on a five-year journey from setting up the Support After Suicide Partnership,

whose vision was that everyone bereaved by suicide is offered appropriate and timely support, I want to thank Public Health England and the Department of Health and Social Care for influencing policy, and particularly NHS England—Tim Kendall, Faye Henney and their team—who have done an amazing job over the last year with a bit of help from friends, Steve Mallen and the Support After Suicide Partnership, to navigate their way through the system and end up with this policy change. It is a huge policy change for 6,000 families every year and should not be underestimated.

Q25 **Chair:** We were interested to hear your further thoughts on that as we are looking at the long-term plan, so thank you.

Hamish Elvidge: We have got there, but it is the start of a journey. We probably have 5% coverage in every area of the country and we need to get to 100%. It will take a lot of effort, focus and determination to do that. Thank you.

Q26 **Diana Johnson:** Can I follow that up with a question about what you said about the police and the coroner identifying at the outset? Do you think there needs to be a legal duty placed on the police and the coroner to do that?

Hamish Elvidge: It would certainly be helpful if there was. I do not understand the true implications of it, but we need to work very closely—NHS England, Public Health England and the police and coroners—to get an effective way of implementing realtime surveillance, which at the moment is done at a local level by local negotiation.

Councillor Kemp: I think, Chair, that is something the LGA would be prepared to look at. The coroner service is of course part of local government in the way the police are. Is that working effectively? We are prepared to take that back from this Committee as a challenge to look at and come back to you, or just to work on it.

Q27 **Chair:** Thank you. I would like to come now to specialist mental health services, turning to you, Peter. This Committee recommended that everybody after discharge from in-patient services should receive a follow-up within three days. That recommendation was not followed up. Can I ask you to clarify where we are now with the follow-up from in-patient mental health services?

Dr Aitken: Certainly. The problem, as you can imagine, if you have been an in-patient in a mental health unit, particularly if you have never been in one before, is that it is a very stigmatising, strange and disorientating experience at a time when you are at your most vulnerable, so it should not surprise us that being made ready to come out, and go back to the community setting that possibly had quite a bit do with why you went into the unit in the first place, is difficult. It is not surprising that in the first few days after discharge from a mental health unit you will be vulnerable. It may be that there is not much in the way of new support for you.

Mental health admissions have shortened, and that is a good thing. When I started training, people went into hospital for months. People now go into hospital for days. The downside of that is that it reduces the amount of time available for safe discharge planning. It means that things are under a time pressure.

The idea was that, recognising that vulnerability, it was very important, if community services were available and in place, to make meaningful contact with people in the period immediately after discharge. The evidence is pretty clear that you want to try to do that within the first couple of days, and, of course, we have weekends and bank holidays, so there is all sorts of detail in discharging a person from a mental health unit that needs to be factored into the service design and the thinking.

The difficulty with targets and reporting against them is that different systems can attempt to meet the ambition of the target in different ways. If a service elects to telephone a patient, or to invite a crisis team to telephone a patient or offers a single point of access, while it might sound like a reasonable attempt to meet the standard, it may not in itself meet the need. It strikes me and many clinicians that it is face-to-face meeting, face-to-face interaction, that matters most.

I would like the Committee to keep their attention on making sure that, when we implement a follow-up target like that in the health service, we are reminded of the rationale for it and the reality of doing it properly. There was a bit of debate earlier this year as to whether, for example, a biopsychosocial assessment in a core 24 liaison psychiatry service could be substituted for by a biopsychosocial desktop review. It sounds like the same thing, but it is the difference between seeing a person and having a meaningful conversation, and looking at some notes and telling another practitioner that all is well. It is that sort of detail that we need to keep our attention on. We need to make sure that targets are meaningful and well met.

Q28 **Chair:** Yes. I think that takes you back to the point you made in your opening comments that it should be more about individual risk reduction than about risk assessment. Just ticking a box is not what you want to do; it is about what you put in place, presumably.

Dr Aitken: Yes.

Q29 **Chair:** Do you think that progress is being made in that area?

Dr Aitken: I do, and I think the college position is in reminding us that risk assessment is to help you see that you are a man of my age and therefore carry some significant risk. Actually, most men of 40 to 43 do not take their own life even when gambling, in debt, drinking and in distressing circumstances. Most do not; very few will, but proportionally more than in other groups.

A lot of time and effort in the NHS goes into identifying which actuarial risk group a person sits in, and that is sometimes mistaken as the task

that matters. Somebody will complete a nice assessment, it will be entered on an electronic patient record, boxes will be ticked and managers will be happy with that, but the point of the meeting has been lost.

We need to move back to the notion of risk reduction. Yes, certainly, it makes a great deal of sense to pay attention to people who are psychotic, and to pay a great deal of attention to people's social circumstances, but really we want to know if people are hopeless and suicidally minded. Are people stuck and absolutely unable to sort out the life crisis they are in? Those are richer things to inquire for, and of course they occur right across society, right across all creeds and cultures and socioeconomic groups.

When you get into the business of meeting people in an A&E department or in a first-responder situation, it is about the ability to listen for hopelessness, the intent to kill oneself, the absolute stuckness of the situation and the impossibility of anybody ever listening. That is the richness in it. The risk reduction element comes from being able to do something about that.

What matters most is a good biopsychosocial assessment. Is there anything we can do biomedically by way of prescription or medical therapy that could help? Is there anything we could do by listening or talking therapies that would, from an evidence base, make a difference? Many of the interventions, I find, are in the social domain. Can we alter this person's living conditions? Can we make sure that they are not going back to loneliness and isolation? Can we make sure that, when they leave the building, they are not going to walk straight back to the triggering situations that led to the risk behaviour in the first place? It is the subtlety of that.

The universities are on this. We see the evidence base for the kind of communication and conversation that works better beginning to emerge. That needs to flow through into the training I talked about earlier, and the training has to be as sophisticated as that. Safety planning, where we equip specialist mental health practitioners to be able to listen and create risk reduction plans that work, needs to be in the next step.

Chair: Thank you very much. Looking at another area around risk reduction, we come to the consensus statement.

Q30 **Dr Whitford:** This is particularly for Peter and Hamish, but obviously others can join in. When we did our first inquiry, we discussed at length the issues around the consensus statement, and the perception, often of medical staff, that confidentiality cannot be broken in any circumstances, and then families finding out after the event, when they have lost someone, that other people knew of the risk and they did not. Why is such limited progress being made on the people involved in these services understanding the consensus statement?

Dr Aitken: My sense is that many of the practitioners I meet day to day from across disciplines understandably stand in awe of the law. The way we are trained in and around our understanding of capacity and consent is that, certainly in English law, and I imagine it is the same in the other jurisdictions, there is a presumption of capacity for adults over the age of 18. On that presumption of capacity, we need their consent to allow us to do certain things.

We have very extensive training in and around capacity, and the end result is that it makes clinicians extremely risk averse. Clinicians are extremely worried that bad things will happen, particularly in the civil courts, if they inadvertently break confidentiality for somebody who was, ultimately, determined to have been capacitous at the point and refusing that information be shared.

You can imagine that in mental health practice it is more ordinary than not to meet people whose mental states are unusual, if not unwell. It is extremely difficult, when coaching and training other clinicians, to help them see that that in itself can be sufficient for the capacity of the person to be understood as temporarily impaired. Part of it comes down to the nature of the decision.

If it is a big decision that is going to lead to irrevocable decline and death, we can all see that you may need a pretty high level of capacity and therefore it is not too difficult to undermine it, but people do not hold something like consent for information sharing in the same immediacy or the same urgency that they might with a more obvious physical consequence to breaking confidentiality.

We have some way to go to help multiagency workers understand that it is like that and that if you do not share information in this setting something very bad could happen; not sharing information in this setting could lead to irreversible decline and death. We may need help from our legal colleagues, from the courts, particularly the Court of Protection, or other agencies, to help us move to a place where clinicians really understand the critical importance of talking to families, carers and supporters about somebody who is vulnerable.

In terms of clinical practice, it is obvious. Psychiatrists and mental health professionals prefer not to make their mind up from just interviewing the person in difficulty; they much prefer to have corroborating information from GPs, other agencies, members of the family and so on. You make a much better opinion if you have a broad picture of a person's life. That is the paradox we sit within. There is anxiety about what the civil consequences would be of getting it wrong, and therefore it is much easier for clinicians to decide not to share than to share.

Q31 **Dr Whitford:** I totally understand that, and the overruling—a surgeon deciding to operate on someone when they are not in a condition to give consent—but do you think it is normal that the issue is raised with a patient? Are all patients being asked, "Would you be comfortable if I let

your family know?" or "Have you thought of that?"

The impression when we did the inquiry before was that in actual fact many people—because not everyone who may be dealing with someone who has attempted suicide is a psychiatrist; it may be A&E, or it may be in all sorts of situations—are not even asking, "Would you be happy if we shared that information or involved your family?"

Dr Aitken: Having just raised a note of caution on tick-box lists of things that one ought to do, certainly in the tick-box lists of things all of us ought to do in my service, whether you are a medical student on the firm through all the different OTs, social workers and mental health nurses I work with, we would always ask and always tick that we had asked. It is right at the top of our assessments on the electronic patient record. There are two things we ask. We ask about that and we ask if there are any children in the family setting; we are interested in safeguarding children and we are interested in the framework for safeguarding adults, and they are both extremely helpful.

The other thing that has helped in my organisation is to have a very expert head of safeguarding who is legally qualified. She is also a nurse by training, so we have that combination: somebody with a legal training who is qualified in a professional discipline and understands the tension and can give guidance to us on these things.

Q32 **Dr Whitford:** Is it being passed on to trainees?

Dr Aitken: It is being passed on to trainees as well.

Q33 **Dr Whitford:** Hamish, obviously this came up a lot in the previous inquiry—families being shut out.

Hamish Elvidge: I remember a conversation with a previous president of the Royal College of Psychiatrists, Sir Simon Wessely. He said that if a professional was involved in providing support, and assessing and treating a patient, and they made a clinical judgment that it would be appropriate to involve a third party in that person's care, because invariably if you involve a third party in somebody's care it will result in a better outcome, he would say, "There is almost a zero chance of being taken to task by the GMC if you record all the information about the decision you made and why you made it."

That really struck home for me, which makes me wonder why a consensus statement that opens the door for information sharing in a way that perhaps it was not before, published in January 2014, five years ago, has had so little penetration in all the professions. It is not only information sharing so that maybe a third party would understand what is going on with the person, not sharing all the confidential stuff. It is understanding what sort of treatments are available and how individuals may or may not respond to them, the risk associated with antidepressants in the first two weeks, the alternative therapies available and the sort of support that is required; there is no barrier to that

information being made available to families, carers and close, trusted friends.

Another thing I talked about last time is consent. Have we now got to a point where every profession understands that there are different ways of asking for consent, which you and I shared on Radio 4 about two years ago? Do you simply say, "Do you want me to share this with your parents?", or do you do the longer one, which is, "In our experience, it is much better to involve a third party, somebody you trust, in your care, in your treatment and recovery, and this would result in a much better outcome. Would you like us to have that conversation now, because it will be good for you?" A number of trusts have implemented that. Merseyside is a zero suicide area and has implemented that. I have spoken at a number of conferences and, as a result, at the end of conferences people come up and say, "Could you tell me what you just said because I want to implement it in my trust?"

What I do not understand, and it really distresses me, is that we are in a situation where the door has been opened, it has been agreed by all the royal colleges, and they are all on the front of that consensus statement, yet we clearly do not have the leadership and the engagement of all those professions to drive the culture and practice changes that we need.

As Sir Simon says, there is no risk associated with it if it is done properly and the clinical judgments are written down, so why isn't there leadership across all the professions to drive this change and move us away from a 40-year historical culture of risk aversion to a situation where that has changed and lives are saved? There is almost a case for reversing the culture, to default to information sharing and managing the risk of not doing so. That is another tricky territory, but would it be better if we were in that situation?

I was talking to Louis Appleby the other day. I do not know whether he is here yet. We set up the Support After Suicide Partnership, and in five years we have achieved support in every area of the country—funded, to come. I wonder whether we ought to set up a consensus statement partnership such that we get everybody around the table and maybe we will be able to achieve the change we need. It needs leadership, it needs a plan, it needs a vision and it needs resource to get the outcome that is required.

Q34 **Dr Whitford:** Is that perhaps part of the problem—that it is only being looked at within the specialty of psychiatric medicine and does not include A&E and all the rest? We talk in suicide prevention about making every contact count and giving people the tools, but if other people are saying, "We cannot ever talk to anyone," we need to get that much wider, as you say, including all the professions.

Hamish Elvidge: We need 100% consistency across GPs, psychiatry, nursing, emergency staff—all the professions—and their staff too, to ensure that this is delivered effectively.

Chair: There are still far too many avoidable tragedies.

Q35 **Andrew Selous:** That was a very helpful form of words that you read out. Would it not be better if that was the standard form of words that every clinician used and people had to explain why they were not going to give permission—to make it a default, as you said, with the specific form of words that you used?

Hamish Elvidge: Yes, it absolutely would be, and I know Steve Mallen is behind me. The Zero Suicide Alliance has 100 NHS trusts signed up. One of their plans is to implement that approach to seeking consent.

Q36 **Andrew Selous:** Dr Aitken?

Dr Aitken: It is the ability to lead this across a whole range of professionals and to apply more broadly the work that is done in psychiatry, and general practice to a degree.

We are almost in the default position the other way around with the service, when we ask the question, "Could there be children at home or not?" We should make sure we have answered the question. Not knowing means that we have not answered the question, and the same is true for, "And have we managed to engage family supporters and friends in a conversation about your presentation today?" If we have not managed to do it, it is a red flag.

We regard people on whose behalf we cannot communicate as at more risk than people who say, "Yes, would you please tell my mum? Would you please ask her to come and help me? I am absolutely desperate for my best friend to know about this. I need to bring help to me. I am vulnerable." That is a safe position. The people who are isolated and lonely and do not allow us to share information are the people we have most concern for. You can turn it around in the culture of a team and you can turn it around in the culture of a service model, but it sounds to me as though we still have work to do to make it cross-profession.

Chair: That is something we would definitely return to next time the Committee looks at this to see what progress there has been. Thank you all very much for your evidence this afternoon.

Examination of witness

Witness: Professor Appleby.

Q37 **Chair:** Welcome back to the Committee, Professor Louis Appleby. I am sorry we kept you waiting on such an important subject. For those following from outside the room, could you introduce yourself and your role?

Professor Appleby: I am Louis Appleby. I am a professor of psychiatry at the University of Manchester, where I lead a research group specialising in suicide prevention. I also chair the advisory group set up

by the Government, the National Suicide Prevention Strategy Advisory Group.

Q38 **Chair:** Thank you very much. I am glad that you were present to hear the first panel. Reflecting on what they said and the publication today on progress, could you let us know what you feel about progress, what you are most encouraged by and where you see the greatest opportunity for further improvements?

Professor Appleby: First, the suicide rate is falling. The suicide rate at the moment is at a figure of 9.2%. The suicide rate has only been lower than that on two occasions since we started measuring it. We started measuring in 1861. Those two occasions were in 2010, when almost certainly the figure was artificially low because of the complication of narrative verdicts, and in 2007, which was the last year pre-recession. At the moment we are at the lowest suicide rate, except for 2007, that we have ever had.

The suicide rate in mental health patients, a group who carry one of the highest risks—just by virtue of being a mental health patient you are at a tenfold increase in suicide risk—has been falling steadily more or less year on year. That may seem odd, given the number of stories we hear about the pressures mental health services are under, and there is no doubt that they are, but the suicide rate is going down, suggesting that, whatever pressure they are under, safety is a priority and safety has improved. For me, those are two vital things.

Thirdly, I have been in suicide prevention for quite a long time, and I do not think there has ever been a time when it has had the political and society-wide profile that it has at the moment. To some extent, the progress report published today is a reflection of that. The number of areas where there are suicide prevention activities is very broad. There is a very encouraging list of areas where suicide prevention has been adopted as an important concern, but there is no question: we have quite a long way to go. There is no doubt about that. There is no question but that there are innumerable things we have not yet got around to doing or tackling, and there are many sectors of society that could sign up more to issues of mental health and suicide prevention. There is no doubt about that at all.

Equally, we are getting support from people who as recently as five or 10 years ago did not seem to be engaged on the issue. That, to me, is taking a slightly more historical view of certainly the last 20 years since the suicide prevention strategy began to be planned. It appeared first in 2002. Things have improved and engagement has improved enormously.

Q39 **Chair:** One group where we are not making progress—in fact, it seems to be getting worse—is young women. Is there anything you would like to comment about on that?

Professor Appleby: It is young people. For me, the greatest concerns continue to be middle-aged men, because they are the group with the highest rate. A third of suicides across society are men in their 40s and 50s, so they remain the group we should be most concerned about. Alongside that group, slightly paradoxically, is the group with the lowest rate of suicide, and that is people under 20. The reason for that is that they are the only group in whom suicide has risen over the last 10 years or so—people aged under 20—and it is in both sexes.

Q40 **Chair:** I would like to hear your opening thoughts on where you see the greatest room for improvement, where we can make the greatest gains overall in policy areas, in reduction.

Professor Appleby: It partly depends on how you define it, but if you commit, as we all did, to a 10% reduction in the suicide rate, you only reduce the suicide rate by that kind of amount—about 10%. Bear in mind that now, in retrospect, it does not seem particularly ambitious, because the rate since 2015, a couple of years ago when it was set, has gone down by 9%. Now, 10% does not seem too ambitious, but the rate at that time, as far as we knew, was still going up. To set a target of a fall in suicide by 10% at a time when the trajectory was upwards was quite ambitious.

If the 10% fall is the target, you only achieve it by paying attention to the groups where large numbers of suicides occur, because you can have a big reduction in suicide in a relatively small circumscribed group; it would have little impact on the population rate, so the priorities of the last couple of years have been people under mental health care. Not only are they at high risk but there are around 1,300 of them per year. It is just worth stressing that 1,300 people under mental health care still die by suicide every year. That is a very important and accessible group. Accessibility is important.

One group where we can put a lot of effort, and where we could do more, are people who self-harm. Roughly half of people who die by suicide have had a previous episode of non-fatal self-harm, or, to put it more positively, they have previous contact with a service where prevention might be achieved. That is around 2,000 people every year.

Then there is the group I was talking about, the middle-aged men. They are different because they are characterised by not being in contact with services. Around two thirds of people who die by suicide have seen their GP in the previous year. The other third are mainly young and middle-aged men. The issue for them is more complex. It is about helping them seek help when they need it, but it starts earlier than that. It means recognising mental health problems when they start and recognising them for what they are, dealing appropriately with them through seeking help, on alcohol and so on. It means having a service that they feel they can go to, which often is not a statutory service because that is not the one they most want.

Where can we make the greatest impact? It is in those three groups, although of course not just in those groups; there are many other groups, but those are the three where a reasonable reduction in the number of deaths would have a big impact on the population problem of suicide because their numbers are big.

Q41 **Chair:** We heard from Ruth Sutherland earlier that she would like the 10% reduction to have been taken, say, from the 2007 rate. Would you support that? Should we have a different target based on that as the baseline?

Professor Appleby: As 2007 was the lowest rate since 1861, people might object to us taking that as a starting point. In some ways, 10% gives us a figure to work towards, but if we hit 10% early, as it looked as if we would, it is not as if people will stop. I do not think the improvement is necessarily all that stable, and it may be that we will find that 10% turns out to be more difficult than it looks at the moment. There are some early signs of that. The key thing is that we get sign-up and priority across the system, not just the health and care system but a whole set of other partner agencies and sectors of society, and that they see this area, which they had previously found difficult and may have been a bit frightened of, as a priority and somewhere they can make a difference.

Chair: Thank you very much. We come now to funding.

Q42 **Martin Vickers:** Professor, you have been involved in identifying many of the spending priorities for the Government funding. What are the first priorities?

Professor Appleby: I am going to put aside the premise of your question. I am not sure whether that is how I would characterise it, but if we are talking about the NHS England money, NHS England eventually had to make the decision about where that money would be best applied.

A number of us in the field made the argument that I have just made, which is that, if the aim is to make big inroads into the total number of deaths across society, the priorities have to be groups where there are large numbers of deaths, because that is where you will get the biggest impact society-wide, not just in that group but society-wide. The three priority areas that I mentioned—mental health services, self-harm care and men, particularly middle-aged men and the issue of access to primary care and other things—came from that recommendation to NHS England. I think it was the right decision. It was not particularly my decision.

Q43 **Martin Vickers:** Clearly, the NHS and, as we heard from the previous panel, local authorities and so on have a key part to play, but many other agencies are involved—the agencies that manage our major infrastructure, the police and so on. How important is it that they receive adequate funding? Will they give us more for our money?

Professor Appleby: They all have a very important role. A lot of that role is working with the NHS, working with the health and care system. Social care is very important as well. I do not welcome the discussion that is mental health services or the NHS versus public health; I do not think that is a particularly helpful way of characterising where we go with suicide prevention, exactly because of the inequities in funding and spending power. Instead, the question is, how can these agencies work collectively to get the most from what is available?

To give you an example, you could easily say that it is a local authority responsibility to look for the frequently used locations, the so-called suicide hotspots. It is not a very good term, but it is in frequent use. You would expect a local area or a local authority, perhaps a department of public health, to be looking around their patch and deciding where are the places they should do more to prevent suicide, because of the physical location or the physical structure of an area—a car park, a bridge or a railway line, for example. That method of suicide is taken by 200 mental health patients per year—200. To think of it as a public health issue and not an NHS issue is missing the point. It is both. The question is how you get public health responsibility and focus, which is often more multiagency and community based, aligned with what the NHS can achieve. It should also include prevention, by the way, and not just the care system.

The money that has gone out through the NHS has been very carefully managed in the sense that it has been given to the NHS but at the same time it has been there for local authorities, public health and other agencies around the local table to comment on and to contribute to discussions about priority. I have been around all the places that have that money; I have been to them all.

It is very interesting that the people who come to meetings about what is going to be done, what the local priorities are, are not just the NHS. They are public health, agencies such as the police, sometimes prisons where there is a high prison population locally, social care, child protection, the voluntary sector, which is very important, and sometimes other kinds of third sector organisations that work with highly troubled people—lifeguards, lifeboats and so on. The group of people around the table in each locality is much broader than the NHS, even though that may be the route through which the money has gone out.

Q44 **Dr Williams:** I am wondering about training. Has enough been done to improve training on suicide prevention, particularly in primary care?

Professor Appleby: It is easy to say no, because who could be against a more skilled primary care workforce? I feel a bit sorry for GPs sometimes. They are a fantastically well-trained part of the NHS workforce, yet every report that comments on where we go with primary care, not just in mental health, says that we need more training. In my experience, I have no doubt that GPs could be more confident about skills in areas of suicide; for example, risk assessment would be helpful.

They are usually fairly well skilled. Young GPs coming through have done mental health attachments; they know about mental health, they know how to assess mental health and quite often they have a decent knowledge of assessing suicide risk. They would say that what they lack is a system around them that will make that training beneficial. That means referral routes, access to secondary care that is prompt and based on urgency, peer support, supervision, the ability to delegate appropriately and, I suppose, support services such as IAPT, which sometimes find it difficult to accept people who might be at high risk. That is a problem. If you run a depression service and you do not want to see people at risk, it is a problem.

It is not a bad thing to say that we need more mental health leadership in primary care. We have good leadership, but of course we could do with more: GPs who take a special interest in mental health and suicide risk, suicide prevention in particular, and GPs who might play a strategic role, linking to the CCG, and deciding not just what happens in clinical care but what services are commissioned locally for referrals and other kinds of support. That would be a good thing. The issue is how we devise a system that works well for people whose location is primary care.

Q45 **Dr Williams:** You do not think there is a big strategic gap in primary care in identifying the people who present the highest risk of suicide. From your answer, that is not a big gap that needs filling. You said it can always be better, but it is not a priority.

Professor Appleby: Having the right skills is a priority and having the right system around those skills is an equal priority. Having one or the other will only be partially beneficial.

Q46 **Dr Williams:** There is no point having one without the other.

Professor Appleby: There is no point having one without the other. I hear about individual cases a lot, and there are a lot of examples where there is no question but that the downgrading by professionals of risk, which appears to be evident to the family, is a problem. Professionals in mental health services—I am a psychiatrist—see a lot of risk, so there is sometimes a difficulty in deciding who stands out as being at more risk on that particular day in that conversation or who is going to be at risk once they have left my office and gone home. Determining in a lot of people at risk who are the people I need to do something extra for can be difficult.

In primary care there is often an equivalent question: given that suicide itself is relatively uncommon in primary care, how do I determine the people who are most at risk? To an extent, that is a slightly distracting question because the real question for primary care is how we do more for people who carry mental health problems. If we build a safer system in primary care, through assessment and having the right services, we will also do more for the most suicidal people, without necessarily identifying them, if that does not sound too illogical, because they are the

people who emerge, sometimes not expectedly, from the group of people who would benefit from better mental health care in primary care.

Q47 **Dr Williams:** That is helpful. My next question is about follow-up from discharge either from in-patient care or from liaison services. What progress are we making around follow-up?

Professor Appleby: It was my research that showed that the peak day for suicide on discharge from mental health services is day three. People hit their risk very quickly, and deaths early following discharge are more likely when there is no care plan. It may seem obvious, but it is quite difficult to research the benefits of some things that we do routinely, and we have reasonable evidence that the immediate post-discharge period is the peak period for suicide risk in the mental health system. Of course, we have been following people up within seven days for some years, and that was progress, but seven days is self-evidently too late and is missing the peak point, so I am very much in favour of a system that operates immediately on discharge. I would still like to see that happen.

Q48 **Dr Williams:** What progress are we making?

Professor Appleby: In the sense we originally talked about, which was placing it as a requirement, we have not got there; that has not happened. On the other hand, people are well aware of that early risk. It is not particularly good evidence, but my impression is that people are now more conscious of immediate post-discharge risk. Some of the ways services fit together for acutely ill patients are partly taking that into account.

How we treat acutely ill people in mental health care has changed. When I trained, there was a ward and then there was the community. Now there is the crisis team, of course, but there are also other kinds of crisis services; the NHS long-term plan talked about a range of crisis services and the way people might move from one to the other, so that people might step down from in-patient care once they no longer needed it, or if for some other reason it was time for discharge. They might be moving to some other better, supported place, so there is acknowledgment in the system that we cannot simply have people leaving the ward and dropping down to a level of care that somebody who had been out of hospital for the previous six months might get. There is a need to grade the drop-off in care to reflect the risk that the person might be facing.

Q49 **Dr Williams:** I am hearing that there is an acknowledgment; there is something in the plan, but sufficient progress has not yet been made in that area.

Professor Appleby: It is still the peak, so sufficient progress has certainly not been made. The bit that is missing is placing a requirement on the system. I would prefer it if we did that. I sort of understand the reasons—there are lots of requirements on the system—but I hope I am making it clear that I would support that.

Q50 **Dr Williams:** Yes. My final question is about improving the treatment of people who self-harm. I still work as a GP and I make it my practice, whenever I hear of one of my patients who has self-harmed, to pick up the telephone the moment I hear about it to speak to them and try to encourage them to come and chat with me further to make sure that follow-up is systematic. What is our treatment of people who self-harm? What progress has been made and what further progress is needed?

Professor Appleby: Previously it has been a highly neglected part of the system and the patients who passed through it have often not been seen as deserving in the same way as other patients can be. Historically, we are starting from a fairly low point. There has been progress, but we are quite a long way from a fully functional system. We talk a lot about parity of esteem between mental health and physical health, but there is no parity of esteem across the mental health system, and this group of patients falls down in that.

What does a self-harm service need? It is not all that complicated. The NICE quality standards are fairly straightforward. They start with compassionate attitudes, which is an incredible thing to start a clinical guideline with, but then they move on to making a proper assessment, a detailed psychosocial assessment; the availability of proven therapies; and, very importantly, the need to have support and treatment available straightaway, because the suicide risk after self-harm, a bit like after discharge from in-patient care, is immediate. The maximum risk is immediately after the episode of self-harm. We have not really got to that.

The majority of acute hospital trusts now offer a reasonable psychosocial assessment at the time of self-harm. They are not necessarily in the position of offering therapy, and, where they do, they probably do not offer it straightaway, so I think we are some way off. There is a plan to have liaison psychiatry, and what we are talking about is a service that probably comes under the badge of liaison psychiatry. There is a plan to expand that and it will be hugely important. It would be better if it was going more quickly, but the limitation is the workforce, as I understand it. We are some way off it, but it is improving a bit.

Q51 **Dr Whitford:** In the first panel, when we were discussing bereavement follow-up after a family has lost someone to suicide, the need for realtime surveillance was mentioned, and early diagnosis that the death was due to suicide. In our previous inquiry we heard about narrative verdicts—you referred to them—and the length of time sometimes for a coroner's report. What kind of progress have we made on the diagnosis that a death has been due to suicide early enough for the family to be supported, as opposed to six months later?

Professor Appleby: We have made some progress, but it is local and patchy. Everything is patchy. There are quite a few areas of the country where they already have a local arrangement. I suppose it is another example of where the wider public health, community-based approach to

suicide prevention matters, because that is often who has instigated so-called realtime surveillance. Quite a few areas of the country now have an arrangement with either the coroner or the police, or both, for early notification once a likely suicide has occurred. What we do not yet have is national co-ordination or a national model, but there is some work towards that.

There is a Public Health England project that is trying to draw on what has been learned by some of what are referred to as local pilots, but what they are really doing is testing out a method that can then be spread, so they are not really pilots; they are just an implementation phase. We have that happening. A number of local areas are doing it, but there will be quite a bit of time before we get to it. We need to get to the point where it is universal, and we obviously are not there yet.

The NHS England plan for bereavement support in every part of the country, although that does not make it universal, is the decisive step, because it is placing bereavement support in the system in a way that has not been there before. *[Interruption.]*

Chair: Thank you very much, Professor Appleby. I am sure we could have kept you longer, but, unfortunately, there is a Division in the House so this will be the point where we say thank you very much for coming this afternoon.

The Committee will adjourn and we will hear from the Minister after the Division in the House. Thank you very much.

Sitting suspended for Divisions in the House.

Examination of witnesses

Witnesses: Jackie Doyle-Price, Professor Newton and Professor Kendall.

Q52 **Chair:** We will resume, with apologies for inconveniencing everybody while we had so many Divisions in the House. Welcome to our third panel. Could we start with all of you introducing yourselves and saying who you are representing today?

Professor Kendall: I am Tim Kendall. I am national clinical director for mental health, but I am also a psychiatrist for homeless people with mental problems in Sheffield.

Jackie Doyle-Price: I am Jackie Doyle-Price, the Minister.

Professor Newton: I am John Newton, director of health improvement at Public Health England.

Chair: It is very welcome to have a suicide prevention Minister as well, so thank you very much. Unfortunately, because of previous commitments, we will not be quorate after 6 o'clock possibly, so we will all try to keep our questions brief, and we would appreciate it if the

answers also could be brief.

Q53 **Andrew Selous:** Good evening, Minister. Could I ask you about the issue of the audit and quality assurance of local authority suicide prevention plans? We have had written evidence from Steve Mallen, who tells us: "Many months have been lost with the LGA's refusal to allow Local Authority Suicide Prevention Plans to be audited and quality assured independently by central Government and potentially graded accordingly." He worries that there is great variety among them and therefore that we are not going to get best practice spread. What is the position on the audit of local authority plans? Why is it not happening?

Jackie Doyle-Price: We want to take that forward in a spirit of partnership with local authorities at this stage, because there is plenty of good will and a desire to do good suicide prevention plans, but not necessarily the expertise. I do not think we want to be in the position of naming and shaming local authority plans that are not good enough. We want to work collaboratively with them to make them better. Steve Mallen is a fantastic campaigner, and he is part of our conscience in holding us to account on this. I have no doubt that we will continue, and I am glad that he is also showing an interest in them.

Q54 **Andrew Selous:** At what point do you start to worry that some of the plans are not good enough, and you will then take follow-up action? I understand the spirit of what you are saying and there is some sense to it. It is fair enough, but presumably you have a point at which you will say that we have to bring the worst up to the standard of the best.

Jackie Doyle-Price: Absolutely. As to where we are now, the local authorities have done their own self-assessment. We are working with the Association of Directors of Public Health Officers to interrogate the quality or otherwise of those plans. We will be sharing best practice. At some point, we will have to take a judgment as to which local authorities need a better push.

Q55 **Andrew Selous:** Can I press you on when that point is likely to be?

Jackie Doyle-Price: We are now working with the ADPH to interrogate the quality of those plans, so we will take a view in spring—not too far away—about how well it is going. I would be more than happy to write to the Committee at that stage, if it would be helpful.

Andrew Selous: That is very helpful, thank you.

Q56 **Dr Williams:** I would like to ask you about the wider prevention of suicide agenda. We have learned today that there is an advisory group and a delivery group. We heard that there is nobody from the DWP and nobody from DEFRA represented, and that perhaps the broader public health approach to suicide prevention is not being considered at a strategic level. Can you reassure us that that is happening?

Jackie Doyle-Price: In terms of the delivery group at official level across Government, DWP and DEFRA are involved; in so far as the national board for suicide prevention is concerned, they are not, but representation of Government comes through me and we invite people as and when. I am sure we will engage with relevant officials from DWP and DEFRA in due course.

Q57 **Dr Williams:** I am particularly thinking about the role of debt, the role of sanctions, and high-risk groups that might work in different professions. Is that something that is integral to your thinking around the prevention of suicide?

Jackie Doyle-Price: It absolutely is. In the plan we produced today, we specifically raised the issues of particular professions that are going to require work. The issue of debt is clearly a major driver. Debt and relationship breakdown are by far the biggest drivers of suicide, so it is very much about that. We have the delivery group at official level, but we also have the inter-ministerial group across Government and we will be making sure that we hold all of Government to account. Part and parcel of having a suicide prevention Minister is to engage Ministers in that work.

Dr Williams: Good.

Q58 **Andrew Selous:** What are Government doing to reduce relationship breakdown, if that is one of the two key drivers?

Jackie Doyle-Price: In so far as we can do anything to reduce relationship breakdown—

Q59 **Andrew Selous:** With respect, there are a number of things we could be doing, looking at the Centre for Social Justice reports and others, and the manifesto for the family written by 60 of our colleagues. There is quite a long list of suggestions.

Jackie Doyle-Price: Perhaps in the interest of brevity, that is not something I will go into in great detail. The best thing a Government can do is make sure that we have the most harmonious, healthy and economically beneficial living conditions for us all to work in, to reduce influences on relationship breakdown. I know you have a lot more to say about that.

Q60 **Chair:** Professor Newton, do you want to come in?

Professor Newton: We deal with other Government Departments in our general public mental health promotion as well, so it is not just around the suicide prevention work. I think you make a good point, and when thinking about prevention of suicide, there are perhaps three levels.

There are the specific things that are in our guidance and in the local plans. There are the public mental health prevention/promotion efforts, including, as we heard, the big campaign on mental health literacy. Then there is addressing the underlying causes of poor mental health, of which

there are many, and we have talked about several of them, including relationship breakdown. That is quite a useful structure. If we are to make a real impact on suicide, all three have to be addressed in different ways.

Q61 **Dr Whitford:** This may be particularly for Tim and John. Since the original report, do you think enough has been done around training, both of doctors already in the system and medical students, on identifying high-risk groups, self-harm, and where to send people? In particular, we have had a lot of discussion around the consensus statement, the issue of trying to involve the family, yet when people from the panel have interacted with medics in different settings, A&E and so on, you are back to the traditional, "We can't talk to anybody. We can't break confidentiality." It strikes me that we have to educate early on. Has that education been changing for young doctors and medical students?

Professor Kendall: Where have we got to? Now, 50% of junior doctors go through at least four months of mental health training, FY1 and FY2. We have started discussions recently with the Royal College of GPs, Health Education England and NHSE, and we are exploring how we could move that to 100% so that all doctors get at least four months of training.

In another area, I have been asked by NHS England's board to look at the treatment of eating disorders, following the PHSO report on that. Part of that is working with the GMC and Universities UK to look at medical school training. It is at an early stage and I cannot say that we have achieved anything, but we are keen to see that medical students have a better exposure to mental health. For example, it used to be that mental health nursing had a separate training course from physical health nursing. They are now merged in the first year—it might even be the first two years—so there is progress on that, but it will take time to come through.

We are aware that for GPs in particular the royal college has created a training programme that includes mental health. They have been doing it for probably 10 years, and it has had quite good mental health content. They would like us to collaborate with them to look at how we could get training to those who are older than that.

Q62 **Dr Whitford:** What about the consensus statement specifically? Outwith psychiatry, someone at risk of suicide could interact with all sorts of parts of the system. People do not seem to be aware, and they still think the traditional confidentiality rules are sacrosanct rather than even having the conversation with the patient.

Professor Kendall: It is a major problem across the whole of medicine and it includes psychiatry. Things such as capacity are not taken into account when someone is deciding about confidentiality. For example, if someone is in the foothills of a hypomanic episode or they are becoming very depressed, it is not uncommon that they might decide to do things

that in other circumstances they just would not do. At that point, talking to their family seems a very reasonable step, and taking into account capacity you might wish to override the patient's wishes. That does not happen enough, and we need some real clinical leadership to make it happen across mental health and outside.

Q63 **Dr Whitford:** Do you think that people are even having the conversation: "Would you like us to get your family involved?" That might happen within psychiatry, but I am not sure it will happen in A&E or other self-harming kinds of environments.

Professor Kendall: I do not have any data, but it would not surprise me that it does not happen anywhere near enough.

Q64 **Dr Whitford:** John, do you want to add something?

Professor Newton: On your earlier point about training, Peter Aitken highlighted the work we are doing with Health Education England, which I think has been very successful on suicide prevention frameworks, for the broader training in suicide prevention for those who might come into contact with people who are at risk. That has gone very well.

As Tim says, there is a broader issue of how we give clinicians confidence to share data. It is not just around suicide prevention but in a whole range of areas. It is a broader discussion that we need to have, possibly with Dame Fiona Caldicott; she might have a view.

Q65 **Chair:** How will you ask the question? Even the document on information sharing, the consensus statement, does not give an example of how you would ask the question in a way that would elicit a different response. If you just ask someone, "Shall I ring your mum?" you are going to get a different answer than if you explain a bit more of the background about why it would be in their best interests, and ask in a different way.

Jackie Doyle-Price: This has been very much something we have explored, or Sir Simon Wessely has explored, as part of the Mental Health Act review. There is an issue about families, because families can often be the source of issues. An early conversation about other trusted people, I think, would make a big difference.

Q66 **Chair:** Yes, but that is explicit in this. It is about the way you ask properly about somebody they trust and you could involve, but there were many wasted opportunities and we are still hearing examples of that happening. One of our earlier panels made the point that maybe you need to shift the perception of risk away from thinking, "Well, I am safe if I don't share," to thinking, "Actually, the risk is in not even asking the questions and considering it." Do you think that is something you need to look at?

Jackie Doyle-Price: We have seen bad outcomes for exactly that, but Tim is right; there is a massive philosophical issue in terms of confidentiality. We need a broader dialogue about it.

Q67 **Chair:** Nobody doubts that it is a really important ethical issue, but we know that we are losing a lot of lives to suicide because people are not even asking the question in a sympathetic and correct way. It is not about wanting to breach confidentiality in all cases, and, as you say, sometimes it may be inappropriate to share. It is when people do not even know that the statement exists or are sometimes hiding behind confidentiality for all sorts of reasons, because they are busy or because they think that they will not be blamed if they say that it is all about confidentiality.

Jackie Doyle-Price: There are people around this table who have been in that position more than I will ever be, so please, Tim, could you share your perspective? It is how we can drive behavioural change to be less risk averse, I think.

Professor Kendall: I think the lead body for this is DH, so could I possibly suggest that after this we have a conversation to see if there is any way in which NHS England, because we are now running out a big national quality programme, could talk to DH and get back to you about what we could do to start a process of getting it addressed?

Q68 **Chair:** You get the sense that it is an area that is not moving on at all.

Professor Kendall: That is because it is so big.

Jackie Doyle-Price: Notwithstanding the desire.

Chair: Yes.

Q69 **Andrew Selous:** Can I make a specific suggestion, following that very helpful exchange between the Chair and Professor Kendall? Hamish Elvidge, who is still with us, had a very good form of words, which he gave us in the last Committee session, and read out on the "Today" programme on Radio 4 not so long ago. Could that statement, or something similar that DH is happy with, be the model statement that is referred to in the document?

What I find extraordinary about the consensus document is that there are three pages about why it is a good idea, but it does not actually have that form of words that was so persuasive to the Committee, and I think to the nation when it was read out on Radio 4. Could you give us a commitment that you will go away, look at Mr Elvidge's form of words, tweak it, if necessary, with all the necessary professional advice that you would want to take, and that it might appear in a refreshed version of the consensus statement?

Professor Kendall: I am sure we could do that, but there is a much bigger mountain to climb, which is to get doctors and nurses in particular to start thinking differently about confidentiality. It is so ingrained: a patient tells you something and that's it. You do not tell anybody else. What the document says is, "Take into account capacity when the decision that is being made to kill yourself is so serious." Your judgment

about that should take into account their capacity for making that decision and for you to not tell relatives. That would be quite a big change.

Q70 **Dr Williams:** Are there conversations that anybody is having with the General Medical Council in terms of amending, updating, improving the "Duties of a doctor" guidance to conduct?

Professor Kendall: I am not aware of any.

Q71 **Dr Williams:** Should there be?

Professor Kendall: Why not?

Q72 **Chair:** Are there not a number of bodies listed in the document?

Jackie Doyle-Price: The document was taken forward in dialogue with all interested parties, but if it is not working, we will look at it again.

Q73 **Andrew Selous:** It is five years out of date as well.

Jackie Doyle-Price: Yes, exactly.

Dr Whitford: It would be great to have an advisory set of words. The doctor will obviously put it in the way they are comfortable using it, but it is a good example. People speak differently in different parts of the country, and if you have an example, it is a place to start, but people around the panel here, or on the Committee, have never even heard of it. It is not even about getting a good frame of words or whatever; people are not aware that the exception is there for someone who may no longer have capacity, or that they can have the conversation. Many people who are in that situation and are at risk of suicide in actual fact would say, "Yes, right enough, but not my dad; get my mum or my brother," or whatever, but if they are not asked, that opportunity is lost.

Chair: Thank you. Did you have anything you wanted to add?

Dr Whitford: The coroner.

Q74 **Chair:** There are a couple of points I want to raise about bereavement support. It is very encouraging to see that in the 10-year plan. Are you able to tell us any more about how you are planning to roll that out and make the greatest difference?

Jackie Doyle-Price: We have set out a clear objective in the plan to roll out much more by way of bereavement services, the principle being that anyone bereaved by suicide will automatically be approached by appropriate services and care put around them. Beyond what is in the plan, I am waiting on the NHS implementation plan to put more flesh on that. Our ambition is very clear and high.

Professor Kendall: We have eight STPs this year, plus Greater Manchester, six more next year, and we will get up to 24 the year after. For all of those, one key step is to make sure that you have realtime

surveillance and that you have local arrangements to get that realtime surveillance in place. Without that, you cannot provide support for families.

Q75 **Chair:** Thank you. I am very glad you made that point, because it brings me on to the issue of how you identify bereaved families accurately and in a timely way. We have had a letter from the coroner to update us on the progress that the coronial system is making.

Professor Kendall: We have to get systems in place, as localities are doing to varying degrees. We have some very good ones in Cornwall, and there are a couple of others. As we find good places, we will spread that to the other STPs we are working with. In the end, we would like to get to the point where, as quickly as possible, when a suicide is recognised, we would be able to provide support for the family. It might not be a suicide; that needs to be borne in mind, but even if it turns out not to have been a suicide, they are likely to need support anyway.

Jackie Doyle-Price: It is still a trauma.

Chair: Yes.

Professor Newton: I think the point was made that there is value in having a national approach to realtime surveillance, and Public Health England is very happy to try to advise on that or to provide it. We tried to do it to some extent, but we need to redouble our efforts to get a national approach.

Q76 **Chair:** There is such variation in the way that reporting happens. We recognise this is a challenge because of coroners not being directly under the direction of the Chief Coroner. Where you are aware that there is variation and there is not best practice, what powers will you have to step in and make sure that best practice is put in place?

Professor Newton: Do you mean in terms of surveillance?

Q77 **Chair:** In terms of surveillance and ongoing rapid provision of support, but also recognising clusters where you need to take faster action.

Professor Newton: If we had access to realtime data at national level, we would be in a much better position to spot any clusters or high-frequency locations. The first thing is to try to persuade all coroners to provide surveillance data. That would be the first thing to do. I do not think it is a question of having powers to insist on it, because the coronial system is very independent, quite rightly. It is about making the argument and making the case that it would be useful to do that. Of course, there is an associated resource problem and we would have to work with that, but I am sure it could be overcome.

Q78 **Chair:** But if you are identifying areas where you are not getting that kind of co-operation from a coroner, accepting that they are independent, are you going to flag that up and have discussions with them?

Professor Newton: We have been working through local authorities and local directors of public health, who obviously work with their local coroners. There is good evidence that, where those relationships are strong, they are working well at local level. As you say, the challenge is to try to get all areas sharing data, at least in some way. It is clearly possible in some areas, so it must be possible to do it more broadly.

Q79 **Dr Whitford:** Before reaching the point of actually sharing the data, we heard of very delayed diagnosis that a death had been due to suicide and, therefore, its coming six months or more later. Unless we get that solved, narrative verdicts and all those things make it seem as if there is difficulty in saying, "I think this death is likely to have been due to suicide." Has that changed in the two years since the report?

Professor Newton: We have done some early work around that and it clearly works in some areas. As you say, the issue is providing a definition for coroners so that they can notify deaths that might be a suicide, and reassuring them that that does not prejudge any future cause of death or registration that they make. That has been the issue and is why some coroners have been happy to do it and others have not; they felt that it prejudged their decision. It is about giving them reassurance that this is a separate process and that we would use it for surveillance purposes, which requires that we have a system that would only use it for surveillance purposes, so it needs careful handling.

Jackie Doyle-Price: At present, of course, the data we have for suicides goes beyond those that are ruled by coroners to be so; it is any questionable death. The coroner's judgment will in many cases take place a long time after the event, so we need to identify potential suicides in order to put the bereavement support in place.

Chair: Thank you. Do colleagues have any further points?

Q80 **Dr Williams:** I want to ask a governance question. We heard earlier from one of the witnesses a critique of the delivery group, that the National Suicide Prevention Strategy Delivery Group had no resource, no power, no delivery capabilities, and was not a fully empowered group. Do you recognise that, and, if you do, is there anything that needs to be done to strengthen the delivery capacity of that group?

Jackie Doyle-Price: I have joined as co-chair so that will help to give it some clout across the system. Again, the agenda of suicide prevention is a whole community approach and a whole Government approach, so it is about bringing together all the people who can make a difference.

My message to all those involved is that we are at a time when we can genuinely make use of their advice and make things happen. Having got to the stage where every local authority has a suicide prevention plan, we are now auditing those to make them effective. We now have a cross-Government approach to make this a priority. I would say very clearly

that this is the time when their involvement and efforts will make a difference.

Q81 **Dr Williams:** Are any other improvements to delivery needed, or is the pace of delivery sufficient?

Professor Kendall: I chair the group that oversees NHS England's £25 million over three years, and that is going to be extended to cover all STPs, in the long-term plan. I chair that group, and I am sure it would not be beyond our abilities to team up, because I am part of the national group anyway. I would have thought we could have conversations about joining forces.

Jackie Doyle-Price: After your inquiry, one of your specific recommendations was that there was a clear plan with timelines, and now we have that. We now have the transparency with which you can all hold us to account.

Q82 **Dr Whitford:** Obviously, it is multifactorial, and the biggest drivers, which Dr Williams touched on, are things such as deprivation and debt, as you mentioned yourself. You describe it as a cross-Government policy. How does that function? Is there actually a sub-Cabinet level group with a health in all policies or a mental health in all policies approach? If we are just digging away trying to fix it, but decisions that are being made quite separately from that are actually feeding it, someone in the most deprived group will have three times the risk of suicide.

Jackie Doyle-Price: We have the mental health inter-ministerial group, which is Cabinet level and meets to review all aspects of mental health policy that impact across Government, of which suicide prevention is one part. Some of the at-risk areas are, for example, the offender population, where I am in close contact with colleagues in the Ministry of Justice specifically to look at that area, and addiction, with gambling, substance and alcohol misuse, where I come together with colleagues in DDCMS and the Home Office.

There is a lot of inter-ministerial working, and one of the objectives the Prime Minister set when she made me Minister for suicide prevention was to re-boot that, because quite often a lot of it happens by accident. I say this all the time. I sit on so many cross-governmental groups; I have offenders on the one hand, rough sleepers on another, and you keep coming back to the fact that it is the same group of people over and over again. They have been in the care system, they have been through prison or they are substance misusers. It all comes back to the same people, and the more we can do to make sure that we are genuinely supporting those who are most at risk and most vulnerable, the more we will solve many problems across society. If doing that through the prism of suicide prevention helps bring that thinking together, it is another happy coincidence.

Q83 **Chair:** Thank you. We could have done with a lot longer, but,

unfortunately, a couple of colleagues have to leave. I am grateful to you, Professor Kendall and Professor Newton, for staying on and to you, Minister, for coming back after the votes. Thank you.

Jackie Doyle-Price: That's all right.

Chair: The progress that has been made is very encouraging, and that has been down, I know, to a lot of hard work across the whole sector, so thank you very much.

Professor Newton: Thank you.

Jackie Doyle-Price: Thank you. We are grateful to all the partners who work with us on this.